

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/05/2016
NAME OF PROVIDER OR SUPPLIER MAPLE GROVE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST MEADOWVIEW ROAD GREENSBORO, NC 27406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews, the facility failed to provide a maintained, safe, and comfortable interior on 3 of 5 resident halls (East Hall, South Hall and North Hall).</p> <p>Findings included:</p> <p>1. From 11:15 PM on 5/2/16 and throughout the survey until 5/5/16 at 10:00 AM, the following areas were observed to be in need of repairs:</p> <p style="padding-left: 20px;">a. East Hall</p> <p>There was missing and peeling paint on both sides of East Hall near the Nursing Station.</p> <p>The door to room 101 had chipped wood and jagged edges that were rough to touch and in need of repair. Inside in room 101 missing paint beside the bed on the wall.</p> <p>The door to room 103 had wood chipped and deep scratches that were rough to touch and missing paint.</p>	F 253	<p>Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding.</p> <p>F - 253 The door for room 101 was sanded on</p>	6/3/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/25/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1 The door to room 104 had chipped woods, jagged edges and missing wood and paint the size of a soft ball. Also in this room the wall behind the resident ' s bed had peeling and missing wall paper and a partially exposed electric outlet. The wall beside the bed was dirty with black marks all over it. The door to bathroom had missing paint. The door to room 105 had chipped woods with jagged edges that were rough to touch and missing paint. The door to room 106 had chipped woods with jagged edges that were rough to touch and missing paint. The door to room 107 had chipped wood with missing paint. The door to room 108 had chipped wood with missing paint The door to room 109 had chipped wood with missing paint. The door to bookkeeping office had missing wood with missing paint. b. South Hall The South Hall between rooms 201 and 202 had missing wall paper at the bottom. The door to room 201 had wood chipped and missing paint. The door to room 202 had chipped wood and jagged edges that were rough to touch and in	F 253	5/5/2016 and assistant, the wall was painted on 5/13/16 by the maintenance director . Room 103 door was sanded on 5/5/16 by the maintenance director and assistant. Room 104 door was sanded on 5/5/16,the wall was repaired and door jam painted both on 5/6/16 by maintenance director and assistant . Room 105 was sanded in 5/5/16 and door jam painted on 5/6/16 by maintenance director and assistant . Room 106 door was sanded on 5/5/16 and door jam painted on 5/6/16 by maintenance director and assistant . Room 107 door sanded on 5/5/16 and door jam painted on 5/6/16 by maintenance director and assistant. Room 108 door sanded on 5/5/16 and door jam painted on 5/6/16 by maintenance director and assistant . Room 109 door sanded on 5/5/16 and door jam painted on 5/6/16 by maintenance director and assistant. The door to bookkeeping office was sanded on 5/5/16 by maintenance director and assistant. The door between rooms 201 and 202 wall was sanded by maintenance director and assistant on 5/6/16. The door on room 201 was sanded on 5/5/16 and painted 5/6/16 by the maintenance director and assistant. The door to room 205 was sanded on 5/5/16 by the maintenance director and assistant. The door to room 207 was sanded on 5/5/16 and painted on 5/13/16 by the maintenance director and assistant .		

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F 253	<p>Continued From page 2 need of repair.</p> <p>The door to room 205 had chipped wood and jagged edges that were rough to touch and in need of repair.</p> <p>The door to room 207 had chipped wood and jagged edges that were rough to touch. Also in the room the wall behind head of the bed had several area with peeling and missing paint.</p> <p>The shared bathroom between 205 and 207 the floor was stained floor with an accumulation of a brown colored substance around the toilet bowl, along the sides of the floor and in the corners and the wall.</p> <p>The shared bathroom between 208 and 210 the floor was stained with significant stain of a red colored substance around the base of the toilet.</p> <p>In room 209 behind the bed the wall paper was torn from the wall that measure approximately 12 " in length and 4 inches width in need of repair.</p> <p>The door to room 211 had chipped wood with jagged edges that with missing paint and rough to touch.</p> <p>In room 212 had wall paper peeling and wall had large vertical abrasion into the wall. In the bathroom had a black ring around the toilets base riser that goes over toilet has odor.</p> <p>In room 225 the toilet had running water in the bathroom, black streaks marks on the floor entering the bathroom, bathroom door has holes up top with peeling of wood in horizontal lines, the door to bathroom was broken off the metal hinge</p>	F 253	<p>The shared bathroom between rooms 205 and 207 had the tile replaced by the maintenance director and assistant on 5/5/16 .</p> <p>The shared bathroom between rooms 208 and 210 was replaced on 5/13/16 by the maintenance director.</p> <p>Room 209 wall had putty applied on 5/12/16 , it was sanded and painted on 5/13/16 by the maintenance director.</p> <p>Room 211 door was sanded on 5/5/16 by the maintenance director and assistant.</p> <p>Room 212 wall had putty applied on 5/12/16 and was sanded and painted on 5/13/16 by the maintenance director.</p> <p>Room 225 toilet was repaired by he maintenance director and assistant on 5/6/16. The marks on the floor were removed by housekeeping staff on 5/5/16 and the door was repaired by the maintenance director on 5/13/16, the baseboard was replaced on 5/10/16 by the maintenance director, the broken tile was replaced on 5/13/16 by the maintenance director and the door was adjusted to promote closure by the maintenance director on 5/14/16.</p> <p>Room 108 wall was painted on 5/6/16 by maintenance director and assistant and the air conditioning unit was repaired on 5/13/16 by the maintenance director.</p> <p>On 5/19/2016 an in-service was conducted by the Vice-president of Operations for the Administrator and Maintenance director for all rooms in the facility to be assessed for needed repairs. A 100% audit was conducted by the</p>		

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F 253	<p>Continued From page 3</p> <p>above the door with 2 screws are exposed and sticking out. Behind the resident bed the baseboard was missing and the wall had missing and peeling paint. The floor bedside the resident bed had broken tile. Odor in the bathroom. The door to 225 would not close going into the hall.</p> <p>c. North Hall</p> <p>In room 108 had missing paint behind resident A bed and had a partially exposed air condition unit. The bathroom had missing paint on the wall next to the toilet and on the doors.</p> <p>During an interview Housekeeping Staff (HS) # 1 on 5/4/16 at 2:15 PM revealed that she had just cleaned room 225 about 30 minutes ago. HS #1 revealed that room 225 had an odor most of the time and the stain on the floor would not come up the strain had been reported to the floor staff (housekeeping staff that deep clean floors). HS # 1 indicated that resident 's room are clean daily by housekeeping staff. HS # 1 revealed that the floor staff are responsible for clean the stain on the resident floor that housekeeping cannot get off. HS # 1 revealed that maintenance manager was aware of the issues in room 225.</p> <p>During an interview with the Maintenance on 5/5/2016 at 9:35 AM revealed that he had work orders for all halls at the Nurse ' s station. Maintenance revealed during this interview that it was the first of the month that only three concerns noted. Review of the work orders revealed no concerns of the resident ' s doors, room ' s condition nor the odors throughout the facility.</p> <p>During an interview with the Administrator and</p>	F 253	<p>maintenance director on 5/6/2016 on all rooms to include doors, walls, and floors and all areas identified were repaired by 5/16/2016.</p> <p>Review to be done daily weekly for 12 weeks, then every other week for 4 weeks, monthly of every room for doors, floors and walls. The Quality Improvement Committee will review weekly X 16 weeks. The Committee consist of Maintenance director, Director of Nursing, ADON□s. QI nurse, medical records supervisor dietary manager, housekeeping supervisor. Any inconsistencies identified will be reported to the Administrator immediately for modification of the quality improvement monitoring process.</p> <p>The Administrator will review this plan with the executive board quarterly X 3 quarters. The executive board consist of Medical Directors, Maintenance director Director of Nursing, ADON□s QI nurse, Dietary manages, Assistant dietary manager, activity director and social worker. The executive committee will discuss recommendations to continue current plan, alter or modify.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 253	Continued From page 4 Maintenance Director on 5/5/2016 at 11:30 AM she indicated the facility had several audits regarding residents ' mattresses residents ' room and residents ' bed side tables since 4/26/16 The Maintenance Director revealed an audit tool for wall issues had been put in place but room 104 and several other rooms were not included. Neither Administrator nor the Maintenance Director were aware of some of the issues in the facility. During an interview with Administrator on 5/5/2016 at 11:45 AM she revealed that her expectation of the facility was to fix all the repairs of the issues brought to her attention and maintenance staff by the surveyor as soon as possible.	F 253			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		6/2/16	

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F 278	<p>Continued From page 5</p> <p>\$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to accurately code the MDS (Minimum Data Set) to reflect the active diagnoses for 1 of 4 residents in the survey sample (Resident # 175). The findings included:</p> <p>Resident # 175 was admitted 09/17/2015 with diagnosis that included Depression, Anxiety, Seizure disorder, and Mood disorder.</p> <p>A quarterly Minimum Data Set (MDS) dated 03/10/2016 revealed Anxiety disorder.</p> <p>Current Physician ' s orders included the following medications: Remeron 7.5 milligrams (MG) take one tablet orally at bedtime, was originally ordered 09/17/2015. In the Lexi-Comp Drug Information Handbook Remeron is listed as an anti-depressant medication. Keppra 500 MG take one tablet taken orally twice a daily, was originally ordered 09/17/2015. In the Lexi-Comp Drug Information Handbook Keppra is classified as an anti-seizure medication. Depakote 125 MG 2 capsules (250) MG twice daily was originally ordered 09/17/2015. In the</p>	F 278	<p>Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding.</p> <p>FTAG 278</p> <p>On 5/16/2016 resident # 175 assessment</p>		

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F 278	<p>Continued From page 6</p> <p>Lexi-Comp Drug Information Handbook Depakote is classified as a mood disorder medication. Seroquel 25 MG 1 tablet orally every evening was originally ordered 09/17/2016. In the Lexi-Comp Drug Information Handbook Seroquel is classified as an anti-psychotic medication (Psychosis)</p> <p>An observation of Resident # 175 on 04/04/2016 at 2:30 PM revealed the resident to be ambulatory on the unit and participating in a unit activity. The resident was pacing from the unit activity to the exit door and back repeatedly.</p> <p>An interview was conducted with the Administrator and the MDS Nurse on 4/04/2016 at 3:30 PM regarding the lack of diagnoses on the quarterly MDS for Resident # 175. The MDS Nurse stated she was new to the position and indicated she was not aware that she was to include all active diagnoses. The Administrator stated she expected the MDS to be coded directly.</p>	F 278	<p>was modified to accurately code resident diagnosis of depression, mood disorder and seizure disorder by the MDS nurse. On 5/16/2016 the modified assessment was accepted by the National Repository. On 5/16/2016, MDS nurses began auditing all in progress and export ready MDS assessments completed for accuracy of active diagnosis coding. Audit was be completed on 5/19/2016. Assessments will be modified for accuracy of active diagnosis coding as necessary. All modified assessments were accepted by the National Repository on 5/20/2016.</p> <p>On 5/16/2016 the MDS coordinator received an in-serviced by the Administrator on section I (resident active Diagnosis). MDS nurses were in serviced by the MDS Coordinator on section I (resident Active Diagnosis)</p> <p>On 5/24/2016 the MDS coordinator will begin auditing MDS assessments for correct active diagnosis using the Diagnosis Accuracy Audit Tool. The MDS Coordinator will audit her and the other 2 MDS nurses assessments. A total of 25% completed assessments will be audited weekly x 12 weeks, then 25% of completed assessment every other week x 4 weeks, then 25% of completed assessments monthly x 3months.</p> <p>The MDS coordinator will report to the QI committee the findings of the Active Diagnosis Accuracy Audit Tool. The QI Committee will review weekly X 12 weeks then every other week X 4 weeks.</p>		

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F 278	Continued From page 7	F 278	<p>The Committee consist of Director of Nursing, ADON□s. QI nurse, medical records supervisor and admission coordinator. . Any inconsistencies identified will be reported to the Administrator immediately for modification of the quality improvement monitoring process.</p> <p>The Administrator will review this plan with the executive board quarterly X 3 quarters. The executive board consist of Medical Directors, Director of Nursing, ADON□s QI nurse, Dietary managers, Assistant dietary manager, Activity director and Social worker. The executive committee will discuss recommendations to continue current plan, alter or modify.</p>		
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff</p>	F 328	<p>Maple Grove Health and Rehabilitation</p>	5/19/16	

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F 328	<p>Continued From page 8</p> <p>interview the facility failed to perform the dressing change to the percutaneous indwelling central catheter (PICC) line as ordered. This was evident 1 of 2 residents in the sample with a PICC line.</p> <p>The findings included:</p> <p>Resident #193 was admitted to the facility on 4/27/16 with cumulative diagnoses which included status post-acute pyelonephritis (kidney infection) and bacteremia (the presence of bacteria in the blood) from methicillin-resistant Staphylococcus aureus (MRSA).</p> <p>Review of the medical record revealed Resident #193 was admitted from the hospital with a PICC line (a form of intravenous access that can be used for a prolonged period of time) for the continued administration of Vancomycin (an antibiotic drug).</p> <p>Record review revealed there was no Minimum Data Set (MDS) assessment or written care plan.</p> <p>Review of the admission physician orders dated 4/27/16 revealed PICC site dressing change to be performed every week.</p> <p>Observation of Resident #193 on 5/4/16 at 11:50 AM during the medication pass revealed the PICC line dressing was dated " 4/27 " with the written initial " KC. "</p> <p>Observation of Resident #193 on 05/04/2016 at 2:44 PM continued to reveal the PICC line dressing dated " 4/27 " with the written initial " KC. "</p>	F 328	<p>acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding.</p> <p>F - 328</p> <p>Resident # 193 noted with PICC line dressing change not done on 5/5/16. Nurse # 4 in service on policy and procedure on frequency of PICC line dressing change on 5/5/16. PICC line dressing changed by nurse # 4 Medical Director notified of site without adverse reaction to dressing change not completed, no new orders were received.</p> <p>An audit completed on 5/5/2016 of all PICC line dressing by the Director of Nursing.</p> <p>All Administrative Nurses in serviced by the Director of Nursing on the Policy and Procedure of dressing changes to PICC lines completed on 5/6/2016</p>		

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F 328	<p>Continued From page 9</p> <p>Continued observation on 5/5/16 at 9:21 AM revealed the dressing to the PICC line remained the same as on 5/4/16.</p> <p>Record review of the medication administration record (MAR) revealed no notation that the dressing change had been performed every week.</p> <p>An inquiry about the dressing change and interview on 5/5/16 at 9:30 AM with Nurse #4 revealed the PICC dressing change was scheduled for yesterday (referring to 5/4/16). Nurse #4 stated that she was responsible for changing the PICC dressing on 5/4/16 but failed to perform the dressing change because she forgot and was not familiar with working on the nursing unit.</p> <p>Interview on 5/5/16 at 11 AM with the Director of nurses revealed her expectation that dressing changes be performed as ordered.</p>	F 328	<p>A 100% in serviced completed by Director of Nursing and Administrative nurses to all licensed nurses on the Policy and Procedure on changing PICC line dressings completed on 5/16/2016 . All new hired licensed nurses will be in serviced during orientation on Policy and Procedure of changing PICC line dressings.</p> <p>All orders for residents with a PICC line will be reviewed by the Director of Nursing and / or Administrative nurses to ensure frequency of dressing change of PICC line dressing completed. All new orders will be reviewed during daily clinical meeting.</p> <p>Review to be done daily X 5 days a week for 12 weeks, then 3 X a week for 4 weeks, then with every new admission or new order for PICC line insertion. The Quality Improvement Committee will review weekly X 16 weeks. The Committee consist of Director of Nursing, ADON's, QI nurse, medical records supervisor and admission coordinator. . Any inconsistencies identified will be reported to the Administrator immediately for modification of the quality improvement monitoring process.</p> <p>The Administrator will review this plan with the executive board quarterly X 3 quarters. The executive board consist of Medical Directors, Director of Nursing, ADON's QI nurse, Dietary manages,</p>		

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F 328	Continued From page 10	F 328	Assistant dietary manager, activity director and social worker. The executive committee will discuss recommendations to continue current plan, alter or modify.		
F 463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and resident interviews, the facility failed to provide functioning call bells for two of seventeen rooms on south hall 200. (Room 212 B and bathroom call light in room 214.) Findings included: 1. An observation was made on 05/03/2016 at 11:32 AM. Resident #3 ' s call bell by the bed in room 212 B was not functioning. The call bell button was observed stuck inside the socket and was unable to be pressed. The call light would not make sound or light up when pressed. An observation was made on 5/3/16 at 3:59 PM. Resident #3 ' s call bell by the bed was not functioning. The call bell button was observed stuck inside the socket and was unable to be pressed. The call light would not make sound or light up when pressed. An observation was made on 5/4/16 at 12:01 PM. Resident #3 ' s call light by bed 212 B was still not functioning. The call light did not light up, make a noise or show up on the call bell box at the nurse ' s station. The resident was observed in bed with</p>	F 463	<p>Maple Grove Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and is order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Maple Grove Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Maple Grove Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/ or any other administrative or legal proceeding.</p>	6/2/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/05/2016
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F 463	<p>Continued From page 11</p> <p>the call bell in reach.</p> <p>Resident #3 was interviewed on 5/4/16 at 12:01 PM. He stated the call bell was how he calls staff but he does not use it. He stated he does not need help.</p> <p>Nurse #4 was interviewed on 5/4/16 at 12:49 PM. She stated resident #3 was unable to use the call bell but was encouraged to use it. Once in a blue moon, the resident would use it. She stated the resident was rounded on regularly. If a call bell was going off then it could be heard at the nurse ' s station and the light would be lit above the resident ' s room. There was also a call bell box at the nurse ' s station that showed the room number from which the call bell was pressed.</p> <p>On 5/4/16 at 12:52 PM, Nurse #4 attempted to get the call bell in room 212 B to work. Nurse #4 confirmed the call bell was not working and stated that it would be fixed right away.</p> <p>The Maintenance Director was interviewed on 5/4/16 at 2:54 PM. He stated the call bells are audited monthly. During the audits, he made sure the call light was on, the call bell made noise and calls at the nurse ' s station. Prior to today, he was not aware that the call bells were not functioning. He stated that work orders are stored at the nurse station and the nurses would fill out a work order if a call bell was not functioning. He stated that a work order was placed today and he replaced the call bell cords for both rooms.</p> <p>The monthly call bell audits sheets were reviewed for the last three months. It revealed that there had not been any problems with the call bell for room 212 B.</p> <p>On 5/4/16 at 2:44 PM, the call bells were tested with the Administrator present. The call bell was functioning.</p> <p>The Administrator was interviewed on 5/5/16 at 3:26 PM. She stated that her expectation was for</p>	F 463	<p>Call bell in room 214 bathroom not working</p> <p>Call bell in room 212B stuck in socket Maintenance Director immediately notified and both sites corrected on 5/4/2016.</p> <p>100% audit performed by the Administrative team on 5/4/2016.</p> <p>All call bell issues immediately corrected by Maintenance Director and Housekeeping manager.</p> <p>A 100% in service initiated on 5/5/2016 by Administrative staff on notification of call functioning status completed 5/19/2016.</p> <p>A 100 % in service conducted by Director of Nursing and Administrative nurses on use of manual call bells for resident usage until call bell repairs completed by 5/19/2016.</p> <p>Administrative staff in serviced by Administrator on call bell audit daily form on 5/9/2016.</p> <p>20% of call bells will be audited daily X 5days a week X 12 weeks by Administrative staff consisting of ADON□s, QI nurse, Assistant dietary manager, housekeeping manager, housekeeping supervisor, activity director, assistant activity director , supply clerk , and medical record supervisor. Any nonfunctioning call bells will be reported to the maintenance director immediately by the auditor for repair .</p> <p>Call bell audit to be performed weekly X12 weeks then every other week X6 weeks then monthly by the maintenance director. All issues to be immediately repaired.</p>		

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F 463	<p>Continued From page 12</p> <p>the call bell to be functioning and, if not, the staff alerts someone so it can be repaired.</p> <p>2.) An observation was made on 05/03/2016 at 11:24 AM. The call light in the bathroom of room 214 was not functioning. The small red light inside the bathroom turned red as if the call bell was functioning. However, the call light did not make noise or light up above the resident ' s room when pressed.</p> <p>Another observation was made on 5/4/16 at 12:08 PM. The small red light inside the bathroom lit up when the call bell in the bathroom of room 214 was pressed. However, the light above the resident ' s door did not come on and the call bell did not make any sound. At the nurse ' s station, the call light station did not beep or light up indicating the call bell was being used. Resident #192 was interviewed on 5/4/16 at 12:08 PM. She stated she doesn ' t use call bell in the bathroom but if she fell she would not be able to get back up. She doesn ' t use her walker in the bathroom but uses the railing in the bathroom. If she was to fall in the bathroom, the first thing she would do was press the call bell. She added that previous to coming to the facility, she had many falls at home. She stated that her roommate was unable to use the bathroom in the room.</p> <p>Nurse #4 was interviewed on 5/4/16 at 12:45 PM. She stated resident #192 was alert and oriented times three. The resident was able to make her needs known and was able to use her call bell. She stated resident #192 was independent with getting herself to the bathroom.</p> <p>On 5/4/16 at 12:52 PM, Nurse #4 attempted to get the call bell in the bathroom of room 214 to work. Nurse #4 confirmed the call bell was not working and stated that it would be fixed right</p>	F 463	<p>Repeated issues and issues that are not corrected to be reported to the Administrator immediately.</p> <p>Maintenance Director to report weekly needed repairs to Quality Improvement team which consist of Maintenance Director, Director of Nursing ,Assistant Director on Nursing, Dietary manager, Assistant dietary manager ,and Activity Director. Reporting will be weekly X 12 weeks, then every other week X6 weeks then monthly for 4 months.</p> <p>The Administrator will review the plan with the Executive committee quarterly X 3 quarters. The executive committee consist of the Medical directors, Director of Nursing, ADONs, QI nurse, dietary manager, assistant dietary manager, activity director, and social worker. The executive committee will discuss recommendations to continue, alter or modify the current plan.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 463	<p>Continued From page 13</p> <p>away.</p> <p>The Maintenance Director was interviewed on 5/4/16 at 2:54 PM. He stated the call bells were audited monthly. During the audits, he made sure the call light was on, the call bell made noise and calls at the nurse ' s station. Prior to today, he was not aware that the call bells were not functioning. He stated work orders were stored at the nurse station and the nurses would fill out a work order if a call bell was not functioning. A work order was placed today and he replaced the call bell cord for both rooms.</p> <p>The monthly call bell audits sheets were reviewed for the last three months. It revealed that on 3/18/16 that a call cord was replaced for room 214.</p> <p>On 5/4/16 at 2:44 PM, the call bell were tested with the Administrator present. The call bell was functioning.</p> <p>The Administrator was interviewed on 5/5/16 at 3:26 PM. She stated that her expectation was for the call bell to be functioning and if not the staff alerts someone so they can be repaired.</p>	F 463			